SERFF Tracking Number:	*SHEN-125837233*	*State:*	*Arkansas*
Filing Company:	*Shenandoah Life Insurance Company*	*State Tracking Number:*	*40403*
Company Tracking Number:	*FORM 6004-9/08 AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Shenandoah Life Insurance Company

Product Name: Application for Life Insurance	SERFF Tr Num: SHEN-125837233	State: ArkansasLH
TOI: L08 Life - Other	SERFF Status: Closed	State Tr Num: 40403
Sub-TOI: L08.000 Life - Other	Co Tr Num: FORM 6004-9/08 AR	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Thomas Mason	Disposition Date: 10/09/2008
	Date Submitted: 09/30/2008	Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/09/2008	
State Status Changed: 10/09/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Re: Form 6004-9/08 AR - Application for Life Insurance

The captioned form is filed herewith for approval by your Department. This form is new, but is substantially similar to, and will be used in the same manner as, Form 4976-Rev. 6/08 AR, which was approved on July 14, 2008.

This form will be used with Forms L-1044-6/08, L-1045-6/08, L-1046-6/08 and L-1048-6/08 approved on July 14, 2008.

The following documentation is also enclosed:

SERFF Tracking Number:	*SHEN-125837233*	*State:*	*Arkansas*
Filing Company:	*Shenandoah Life Insurance Company*	*State Tracking Number:*	*40403*
Company Tracking Number:	*FORM 6004-9/08 AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*/*		

Readability Certification

We trust that you will be in a position to give this filing an early review. If you have any questions or need additional information, please so advise.

Sincerely,

Pamela N. Ferguson
Director, Legal Services

Attachments

Company and Contact

Filing Contact Information

Pamela Ferguson, Director, Legal Services	pam.ferguson@shenlife.com
P.O. Box 12847	(800) 848-5433 [Phone]
Roanoke, VA 24029	(540) 857-5987[FAX]

Filing Company Information

Shenandoah Life Insurance Company	CoCode: 68845	State of Domicile: Virginia
2301 Brambleton Ave. SW	Group Code: 891	Company Type: Life and Health
P.O. Box 12847		
Roanoke, VA 24029	Group Name:	State ID Number:
(800) 848-5433 ext. [Phone]	FEIN Number: 54-0377280	

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	$20.00 per application form, if filed separately from the basic policy form
Per Company:	No

SERFF Tracking Number:	*SHEN-125837233*	*State:*	*Arkansas*
Filing Company:	*Shenandoah Life Insurance Company*	*State Tracking Number:*	*40403*
Company Tracking Number:	*FORM 6004-9/08 AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*/*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shenandoah Life Insurance Company	$20.00	09/30/2008	22827655

SERFF Tracking Number:	*SHEN-125837233*	*State:*	*Arkansas*
Filing Company:	*Shenandoah Life Insurance Company*	*State Tracking Number:*	*40403*
Company Tracking Number:	*FORM 6004-9/08 AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/09/2008	10/09/2008

SERFF Tracking Number:	*SHEN-125837233*	*State:*	*Arkansas*
Filing Company:	*Shenandoah Life Insurance Company*	*State Tracking Number:*	*40403*
Company Tracking Number:	*FORM 6004-9/08 AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/09/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SHEN-125837233*	*State:*	*Arkansas*
Filing Company:	*Shenandoah Life Insurance Company*	*State Tracking Number:*	*40403*
Company Tracking Number:	*FORM 6004-9/08 AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		No
Supporting Document	Application		Yes
Supporting Document	Readability Certification		Yes
Form	Application for Life Insurance		Yes

SERFF Tracking Number:	*SHEN-125837233*	*State:*	*Arkansas*
Filing Company:	*Shenandoah Life Insurance Company*	*State Tracking Number:*	*40403*
Company Tracking Number:	*FORM 6004-9/08 AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: Form 6004-9/08 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 6004-9/08 AR	Application/ Enrollment Form	Application for Life Insurance	Initial			6004_ar.pdf

Application For Life Insurance

SHENANDOAH LIFE INSURANCE COMPANY

1. PROPOSED INSURED INFORMATION

Last Name	First Name	MI	Phone Number for Contact
			Day

Social Security Number or Tax ID #	Sex	Date of Birth	State of Birth	E-Mail Address	Evening
					Best Time To Call

Primary Mailing Address	City	County	State	Zip Code

Mail Policy To: ..... ❑ Owner ❑ Agent/Producer

2. BENEFICIARY INFORMATION

Primary Beneficiary	Relationship	Telephone Number

Address of Primary Beneficiary	City	County	State	Zip Code

Contingent Beneficiary	Relationship	Telephone Number

Address of Contingent Beneficiary	City	County	State	Zip Code

3. OWNER *(if other than Proposed Insured)*

Last Name	First Name	MI	Social Security # or Tax ID #	Relationship to Proposed Insured

Street Address	City	County	State	Zip Code	Telephone Number

4. HEALTH INFORMATION (*circle any condition which applies)*

Has the Proposed Insured smoked cigarettes in the past 12 months? ..... ❑ Yes ❑ No

Please state the Proposed Insured's height _____ and weight _____.

Part A - if any question is answered "Yes", the proposed insured is not eligible for coverage

1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care, confined to a wheelchair due to a chronic illness or disease, or waiting for an organ transplant? ..... ❑ Yes ❑ No
2. Has the Proposed Insured ever had, been told they have, been diagnosed, been treated, or taken medication for Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? ..... ❑ Yes ❑ No
3. If the Proposed Insured is **under the age of 25**, has the Proposed Insured ever had, been told they have, been treated, or taken medication for: cerebral palsy, Downs Syndrome, spina bifida, cystic fibrosis, diabetes treated by insulin, mental retardation, or muscular dystrophy? ..... ❑ Yes ❑ No

Part B - if any question is answered "Yes", the proposed insured may be eligible for Shenandoah New Vista℠ 3

1. Has the Proposed Insured ever had, been told they have, been diagnosed, been treated, or taken medication for Alzheimer's disease, organic brain syndrome or dementia? ..... ❑ Yes ❑ No
2. Has the Proposed Insured been advised to have surgery or biopsy that has not been done? ..... ❑ Yes ❑ No
3. In the past **2 years**, has the Proposed Insured had, been told they have, been diagnosed, been treated, or taken medication for drug or alcohol dependency/habit or treatment for alcoholism or drug addiction? ..... ❑ Yes ❑ No
4. In the past **3 years**, has the Proposed Insured had, been told they have, been diagnosed, been treated, or taken medication for: internal cancer, malignant melanoma, or leukemia? ..... ❑ Yes ❑ No

4. HEALTH INFORMATION (*circle any condition which applies) (Continued)*

Part C - if any question is answered "Yes" to "During the past 2 years", the proposed insured may only be eligible for Shenandoah New Vista℠ 3. If any question is answered "No" to "During the past 2 years" but "Yes" to "During the past 5 years", the proposed insured may be eligible for Shenandoah New Vista℠ 2

1. Has the Proposed Insured had, been told they have, been diagnosed, been treated, or taken medication for:	During the past 2 years?	During the past 5 years?
a. Brain tumor, pacemaker, coronary artery disease, heart attack, heart surgery to include heart bypass, angioplasty, balloon procedure, stent placement or heart valve replacement, stroke, aneurysm, angina, chest pain, Congestive Heart Failure (CHF) or any other heart or circulatory disorder?	❑ Yes ❑ No	❑ Yes ❑ No
b. Chronic Obstructive Pulmonary Disease (COPD), which includes emphysema, chronic asthma, chronic bronchitis, or any other chronic respiratory disorder, or a disease that requires the use of oxygen to assist with breathing?	❑ Yes ❑ No	❑ Yes ❑ No
c. Parkinson's disease, kidney dialysis, kidney disease, kidney failure, cirrhosis or other liver disease?	❑ Yes ❑ No	❑ Yes ❑ No
d. Diabetes treated by insulin?	❑ Yes ❑ No	

If all questions in Parts A, B and C are answered "No", the proposed insured may be eligible for Shenandoah New Vista℠ 1

5. INSURANCE APPLIED FOR

a. ❑ Shenandoah New Vista℠ 1 ..... ❑ Full Pay ❑ Single Premium ❑ 10-Pay ❑ 20-Pay

❑ Shenandoah New Vista℠ 2

❑ Shenandoah New Vista℠ 3

b. Face Amount ..... $_____

6. RIDERS APPLIED FOR

❑ Accidental Death Benefit Rider ..... $_____ ❑ Other _____

❑ Nursing Home Waiver of Premium Rider

If applying for Nursing Home Waiver of Premium Rider, does the proposed insured require assistance from another person in bathing, dressing, eating or toileting? *(If yes, list details in Comments section below)* .... ❑ Yes ❑ No

Comments: _____

_____

7. PREMIUM AND BILLING INFORMATION

1. Premium Information:
   a. Premium ..... $_____
   b. Billing Type ❑ EFT ❑ Direct Bill ❑ _____ Not Applicable _____
   c. Premium Mode (Not applicable for Single Premium)

   NOTE: If you choose to pay your policy premium in semi-annual, quarterly or monthly payments, you will pay more over the year than if you choose to pay your premium in one annual premium payment.

   ❑ Monthly (Not available for direct bill) ❑ Quarterly ❑ Semi-Annual ❑ Annual
2. Payment with Application ..... $_____

   NOTE: Please complete Form 1019 if paying by credit/debit card (credit/debit card payment not available for single premium purchase).
3. Premium notices sent to: ..... ❑ Proposed Insured ❑ Owner ❑ Other *(indicate below)*

Name	Relationship to Insured	Social Security # or Tax ID #

Address	City	State	Zip Code

4. Automatic Premium Loan ..... ❑ Yes ❑ No

   I understand that by selecting this option a loan may be made against the cash value of my policy to pay premiums due.

8. FOR EFT PREMIUMS ONLY

I hereby authorize Shenandoah Life Insurance Company to make withdrawals from my account, indicated below, for the purpose of paying premiums on any policy issued on this application.

CHECK ONE:

❑ Checking **For a Checking account, please attach a voided check.**

❑ Savings **For a Savings account, please complete the following information. Ask your financial institution to verify that this EFT will be accepted and that the information below is correct.** *This verification is necessary as not all financial institutions will acknowledge an EFT debit to a savings account.*

Financial Institution Name	Telephone Number	Transit Routing Number

Financial Institution Address

Depositor Address	Depositor Account Number

Please withdraw on the _____ day of the month (please choose a day between the 1st and the 28th). If a day is not selected, Shenandoah Life will select the day nearest the premium due date.

I agree that the withdrawals on this account and financial institution shall constitute due notice of premiums being due upon the policy. The withdrawals reflected on my account statement will constitute a receipt. This authorization is revocable only upon receipt by Shenandoah Life Insurance Company of a written notice of revocation. I understand that if any account withdrawal is not paid upon presentation and any premiums due on the policy are not paid within the time stipulated in the policy, insurance coverage may lapse or may be terminated by Shenandoah Life Insurance Company. A notification to stop EFT should be received by Shenandoah Life Insurance Company at least 5 days prior to the day of withdrawal.

X_____ _____ _____

Signature exactly as it appears on financial institution records | Print name of depositor, if other than proposed insured | Date

9. REPLACEMENT INFORMATION

a. Is there life insurance in force on the person proposed for coverage? ..... ❑ Yes ❑ No
If yes, list all life insurance coverage below.

b. Will insurance applied for replace any life insurance in force? ..... ❑ Yes ❑ No

c. Are any other applications pending with other companies? ..... ❑ Yes ❑ No

Insured's Name	Company	Owner	Replacement	Life Amount	Accidental Death Benefit	Year Issued
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			

10. HOME OFFICE ENDORSEMENTS	SPECIAL REQUESTS

11. DECLARATIONS AND AUTHORIZATIONS

By this application, I am applying to Shenandoah Life Insurance Company ("SHENANDOAH") for a policy of life insurance. **I agree that:**

1. My statements and answers to the questions in this SHENANDOAH application are complete and true to the best of my knowledge and belief, and are the basis for issuing any policy.
2. **No insurance shall become effective unless a policy has been issued and delivered to me, the first premium paid and my insurability as stated in this application remains unchanged.**
3. Acceptance of any policy issued on this application shall constitute agreement to any correction or amendment of this application made by SHENANDOAH and noted on this application. However, no change in amount, age at issue, classification, plan of insurance or benefits applied for shall be made unless agreed to in writing by me.
4. No broker or agent has the authority to waive any of SHENANDOAH's rights or requirements, or to make or alter any contract or policy.
5. During the contestable period, SHENANDOAH has the right to rescind any policy issued upon statements or answers in this application that are not correct.

I authorize any medical professional, hospital, clinic, medical care institution, insurer or reinsurer, the MIB, Inc., consumer reporting agency, employer, relative, friend or neighbor to disclose to SHENANDOAH, its reinsurers, and, except for the MIB, Inc., any consumer reporting agency acting on behalf of SHENANDOAH, medical and other information pertaining to me. The information that may be disclosed includes information relating to employment; other insurance coverage; past and present physical, mental, drug and/or alcohol conditions; character; habits; avocations; finances; general reputation; credit or other personal characteristics.

I understand that SHENANDOAH may collect information for the purpose of determining eligibility for insurance. I agree that this authorization will be valid for two and one-half years from the date it is signed. I know that I or my authorized representative have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

Any person who, knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I acknowledge that I have received the Investigative Consumer Report Notice and MIB, Inc. Disclosure Notice or I understand that such notices will be mailed to me within 24 business hours.

Signed at _____ on _____
City, State Date

X _____ **X** _____
Signature of **Proposed Insured** Signature of **Owner**, if other than Proposed Insured

12. AGENT CERTIFICATION

To be completed by agent. Do you have knowledge or reason to believe that this application replaces existing life insurance? ..... ❑ Yes ❑ No

Unless the application is taken by telephone and the application questions were asked by a Company representative, I certify that I have asked the persons proposed for coverage all of the questions contained in this application and have accurately recorded on this application the information supplied by the persons proposed for coverage.

Is the agent an immediate relative of the proposed insured? .... ❑ Yes ❑ No Relationship _____

Print Agent's Name	Agent's Code	Telephone Number	**X** Agent's Signature
Print Agent's Name	Agent's Code	Telephone Number	**X** Agent's Signature

SHENANDOAH LIFE INSURANCE COMPANY

CONDITIONAL RECEIPT (Please detach and leave with applicant if payment is accepted with application)

Prior to the delivery of the policy, coverage will be effective only when ALL of the following conditions are met:

a) The full first premium according to the mode of payment specified in the said application has been tendered and honored for payment when presented;

b) A later date is not requested in the application;

c) The Proposed Insured is on that date an acceptable risk under the Company's rules, limits and standards as to plan, benefits, class, and amount for the policy applied for; and

d) There is no material misrepresentation in the application furnished to the Company.

Subject to satisfactory completion of all of the above conditions, coverage under this receipt will begin on the date the application is signed.

The maximum death benefit and all other supplemental benefits provided by this receipt will be the lesser of a) the total death benefit payable under the policy(ies), including any Accidental Death Benefit, on all pending applications with the Company or b) $250,000.

If any condition under this receipt is not met, the Company's only liability will be to refund the premium payment. Either the Company or the proposed owner may terminate coverage under this receipt by notice to the other. In no event will coverage under this receipt be in force after 60 days from the date of the application.

No broker, agent or medical examiner may waive a complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements.

If there is material misrepresentation in the application (or in any medical information furnished to the Company), the Company's only liability will be limited to refunding the premium payment.

If the proposed insured commits suicide, whether sane or insane, the Company's only liability will be limited to refunding the premium payment.

If any question in 4A has been answered YES, no payment will be accepted with this application.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO SHENANDOAH LIFE INSURANCE COMPANY.
NO PREMIUM CHECKS SHOULD BE PAYABLE TO ANY AGENT OR A BLANK PAYEE.

Received $_____ from _____ for an application on _____ dated _____.

X_____ **X**_____

Signature of **Owner** Signature of **Agent**

AUTOMATIC PAYMENT AUTHORIZATION (Please detach and leave with applicant)

As a convenience to me, I request and authorize you, until revoked by written notice, to initiate debit entries (charges), electronically, by paper means or by any other commercially accepted method, to my account for payment of premiums, provided there are sufficient funds in my account to pay the debits. I understand this authorization is applicable only if requested on my application.

MIB PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. Shenandoah Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Ste. 400, Braintree, Massachusetts 02184-8734.

Shenandoah Life Insurance Company or its reinsurers may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INSURANCE INFORMATION PRACTICES

1. Personal information may be collected from persons other than the individual or individuals proposed for coverage.
2. Such information, as well as other personal or privileged information subsequently collected, may be disclosed to third parties in certain circumstances, without authorization.
3. A right of access and correction exists with respect to all personal information collected.
4. A more complete notice describing our information practices in detail will be furnished to you upon request.

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION

As part of our procedure for processing your initial application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon furnishing proper identification, you have the right to make a written request within a reasonable period of time to inspect and/or receive a copy of the report and/or to receive additional, detailed information about the nature and scope of this investigation. For this information you may write to the Underwriting Department, Shenandoah Life Insurance Company, P.O. Box 12847, Roanoke, Virginia 24029. This notice is in compliance with the Fair Credit Reporting Act (Public Law 91-508).

Note: Within 60 days of the date of this application you will be notified as to whether or not this application has been accepted or else be given the reason for any further delay.

SERFF Tracking Number:	*SHEN-125837233*	*State:*	*Arkansas*
Filing Company:	*Shenandoah Life Insurance Company*	*State Tracking Number:*	*40403*
Company Tracking Number:	*FORM 6004-9/08 AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SHEN-125837233*	*State:*	*Arkansas*
Filing Company:	*Shenandoah Life Insurance Company*	*State Tracking Number:*	*40403*
Company Tracking Number:	*FORM 6004-9/08 AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Life Insurance*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Application 09/29/2008

Comments:

See Form Schedule tab for the application form

Review Status:

Satisfied -Name: Readability Certification 09/30/2008

Comments:

Attachment:

READABILITY CERT_BASE.pdf

SHENANDOAH LIFE INSURANCE COMPANY

READABILITY CERTIFICATION

This is to certify that the form referenced below is in compliance with the readability requirements of your state.

The Flesch Reading Ease Test was applied to the form.

FORM NUMBER	SENTENCES	WORDS	SYLLABLES	FLESCH SCORE
Form 6004-9/08	87	1,314	2,077	57.8

Kathleen M. Kronau

Signature of Company Officer

Kathleen M. Kronau
Vice President and General Counsel

Type Name & Title of Person Signing

September 26, 2008

Date